MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
COMMUNITY FOOD AND NUTRITION ASSISTANCE
SUMMER FOOD SERVICE PROGRAM

CLAIM FOR REIMBURSEMENT

1. CONTRACT NUMBER	2. VENDOR NUMBER	3. NAME AND ADDRESS OF SPONSOR
		Sponsor Name: _____
READ INSTRUCTIONS ON REVERSE BEFORE COMPLETING CLAIM		
4. MONTH AND YEAR CLAIMED _____ _____ ORIGINAL ☐ REVISION (1,2,3, etc.) ☐	5. CLAIM PERIOD _____/_____/_____ to _____/_____/_____	Address: _____ _____ City/State/Zip: _____
6. DAYS OF OPERATION	7. AVERAGE DAILY ATTENDANCE	

MEALS SERVED TO PARTICIPANTS	CHILDREN MEALS			ADULT MEALS	
	FIRST MEALS	SECOND MEALS	NONPROGRAM / DISALLOWED	PROGRAM	NONPROGRAM
8. BREAKFAST					
9. LUNCH					
10. SUPPER					
11. SNACK					

REPORTED OPERATIONAL COST	REPORTED PROGRAM INCOME	REPORTED ADMINISTRATIVE COST
12. $	13. $	14. $

I certify that all sites for which approval has been given were operational during the month claimed and that there has been no significant change in projected administrative costs since submission of program application, receipt of advance payment or previous claim.

I certify that all enrolled sites had 50% or more eligible participants for the claim period represented on this form.

I certify that to the best of my knowledge and belief, this claim is true and correct in all respects, that records are available to support this claim, that this is in accordance with the terms of existing agreement(s). I recognize that I will be fully responsible for any excess amounts that may result from erroneous or neglectful reporting herein.

15. SIGNATURE OF AUTHORIZED REPRESENTATIVE	TITLE	DATE
▶		

All records supporting claim for reimbursement must be retained and available for a future audit for a period of 3 years and the current year.
No further monies or other benefits may be paid out under the Program unless this report is completed and filed as required by existing regulations.

MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES USE ONLY

OPERATIONAL	$	
ADMINISTRATIVE	$	
TOTAL	$	

MDHSS SFSP AUTHORIZED REPRESENTATIVE	DATE
▶	
REVISION PREPARED BY DISTRICT NUTRITIONIST	DATE
▶	

INSTRUCTIONS FOR CLAIM PREPARATION	
1. Contract Number	The number assigned by the State agency and noted on the contract.
2. Vendor Number	The number assigned by the State agency and reported on the Vendor Input Form.
3. Name and Address of Sponsor	Attach preprinted labels included in the claim packet.
4. Month and Year Claimed Original Revision	The last month of operation reported on this claim. Report the last month on this claim if for more than one month. Check Original if this is the first claim submitted for this claim period. If this claim is a revision, enter the number of claims submitted including this one for this claim period.
5. Claim Period	Enter the first and the last date of operation for this claim.
6. Days of Operation	Total number of days in operation included on this claim.
7. Average Daily Attendance	Please leave blank.
TOTAL MEALS SERVED	
CHILDREN MEALS 8-11 First Meals	Enter the total number of allowable first meals, by meal type, served to eligible participants for this claim month.
8-11 Second Meals	Enter the total number of second meals, by type, served to eligible participants
8-11 Non-Program/Disallowed	Enter the total number of meals served to children who do not qualify for the SFSP (i.e., camps). Enter the number of disallowed meals.
ADULT MEALS 8-11 Program	Enter the total number of meals served to adults working or volunteering with the program.
8-11 Non-Program	Enter the total number of meals served to adults that are not associated with the SFSP.
PROGRAM COSTS FOR THE CLAIM MONTH	
12. Reported Operational Cost	Enter the sum of all documented expenditures associated with the preparation and service for all of the meals.
13. Reported Program Income	Include all funds received from any source, except USDA program funds, that were used to support the SFSP. This includes payments for adult meals.
14. Reported Administrative Cost	Report actual documented Administrative Costs incurred during this claim period. (Check approved administrative budget, revise if participation increases or expenditures exceed projections. **REVISIONS CAN ONLY BE PROCESSED WHILE YOUR PROGRAM IS IN OPERATION.)**
15. Signature, Title, and Date Prepared	Signature required for payment of claim.

ADVANCE PAYMENTS WILL BE DEDUCTED FROM CLAIMS FOR REIMBURSEMENT.

Mail or Fax Claim for Reimbursement to:

Missouri Department of Health and Senior Services
Community Food and Nutrition Assistance
P.O. Box 570
Jefferson City, MO 65102-0570
Fax: 573-526-3679